State of Connecticut
Department of Developmental Services

Dannel P. Malloy
Governor

Morna A. Murray, J.D.
Commissioner

Jordan A. Scheff
Deputy Commissioner

First Notice

Date:

Re: DDS#:

A review of records indicates that_____is receiving residential, day and/or individual support services that are funded by the Department of Developmental Services.

Subsection g of section 17a-218 of the Connecticut general Statues requires all individuals who receive substantive services from DDS to enroll in the DDS Medicaid Home and Community Based Services Waiver.

If you do not qualify for Medicaid at this time due to earned and/or unearned income, asset resources, trusts, etc., you must provide documentation of income, assets, and trusts to your case manager.

Please contact your case manager within **10 days** to complete the waiver enrollment process, or, to submit the requested supporting documentation of Medicaid ineligibility within 30 days from the date of this letter. Please be advised that failure to contact your case manager will result in a case review which may lead to the termination of DDS funding for supports and services.

Please see the attached factsheet for additional information.

Supervisor of Case Management

Phone: 860 418-6000 ♦ TDD 860 418-6079 ♦ Fax: 860 418-6001
460 Capitol Avenue ♦ Hartford, Connecticut 06106
www.ct.gov/dds ♦ e-mail: ddsct.co@ct.gov

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Governor

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DDS

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Second Notice

Date:

Re: DDS#:

This is a follow-up to the letter you received dated_____.

Please be advised that failure to contact your case manager to complete the waiver enrollment process or, to submit the requested supporting documentation of Medicaid ineligibility within 30 days from the date of the first letter dated _____will result in a case review which may lead to the termination of DDS funding for supports and services.

Please contact your case manager to avoid termination.

Regional Director or designee

Attach factsheet
Copy DDS.Waiver@ct.gov

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Final Notice

Date:

Re: DDS#:

DDS has made several attempts to address the waiver enrollment and/or Medicaid application process for _____.

You were notified that termination of DDS funding for supports and services would occur at the end of 30 days from your original letter dated ____. Our records indicate that you have not made contact with your case manager, which has resulted in termination of DDS funding for support and services effective the end of this month.

If you believe you have received this letter in error. Please contact the DDS Waiver Unit at:

Department of Developmental Services
HCBS Waiver Unit
460 Capitol Avenue
Hartford, CT 06106
Phone: 860-418-6028
Fax: 860-622-2769
Email: DDS.Waiver@ct.gov

Please contact your case manager to avoid termination.

Note you have the right to appeal this decision through the Fair Hearing Process at DSS. See the attached form and factsheet for additional information.

DDS Waiver unit sends this letter
Copy provider
Copy regional Director